STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUI	DINC	00	COMPLETED	
		155115	A. BUII B. WIN			09/23/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
CARDINI	AL NUIDOING AND	REHABILITATION CENTER			LASALLE AVE I BEND, IN46617		
	AL NURSING AND	REHABILITATION CENTER		300111	BEND, IN40017		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	or a Recertification and	F0	000			
	State Licensure S	Survey. This visit resulted					
	in an Immediate	Jeopardy.					
	Survey dates: Se	eptember 19, 20, 21, 22,					
	2011	Promoti 17, 20, 21, 22,					
		date: September 23,					
	_	date. September 23,					
	2011						
	Facility number:						
	Provider number	r: 155115					
	AIM number: 10	00275330					
	Survey team:						
	Sandra Haws, R	N ₋ TC					
	•	RN- September 19, 20,					
		-					
	21, and 23, 2011						
	Toni Krakowski						
	Bobbie Costigan	ı, RN					
	Census bed type	:					
	SNF/NF: 107						
	Total: 107						
	10001. 107						
	Census payor ty	ne.					
	Medicare: 11	ρε.					
	Medicaid: 80						
	Other: 16						
	Total: 107						
	Sample: 22						
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURI	Ξ	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DEQ911

Facility ID:

000048 If continuation sheet

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JETIPLE CO.	NSTRUCTION 00	(X3) DATE S COMPLI	
ANDILAN	or correction	155115	A. BUII			09/23/20	
		100110	B. WIN		DDDEGG CHTV CTATE TID CODE	05/20/20	311
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE		
CARDINA	AL NURSING AND I	REHABILITATION CENTER			BEND, IN46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0371 SS=L	These deficiencies findings cited in 16.2 Quality review con 28, 2011 by Bev The facility must - (1) Procure food from the on the immediate jewhen numerous as its findings cited in the immediate jewhen numerous cited in the immediate jewh	es also reflect State accordance with 410 IAC completed on September Faulkner, RN om sources approved or ctory by Federal, State or nd distribute and serve food	F0	371	It is the practice of this provious procure food from sources approved or considered satisfactory by Federal, State local authorities and to store, prepare, distribute and serve under sanitary conditions. With corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice: All specifically iden areas in the kitchen and dry storage areas have been thoroughly deep cleaned and	e or food hat en tified food	10/23/2011

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 00/22/2011
		155115	B. WIN	G		09/23/2011
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		1121 E	DDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	food storage area Director of Nurs Manager, and the Assistant were n jeopardy at 2:30 immediate jeopa 9/21/11, but non the lower scope widespread, no a for more than minediate jeopa Findings include 1. During initial at 11:10 A.M., a Dietary Manager droppings were drareas: 1. On the floor imixer. 2. On the floor in mixer. 3. Under the sin prep area. 4. On a small le approximately for directly behind to tables. 5. On the same sopposite side of large utility rack of the floor in th	a. The Administrator, ing (DON), Dietary e Dietary Manager otified of the immediate P.M. on 9/19/11. The rdy was removed on compliance remained at and severity level of actual harm with potential inimal harm that is not rdy. Ekitchen tour on 9/19/11 ecompanied by the r Assistant, multiple mice observed in the following on the corner behind the opening the sink next to the food		TAG	sanitized. How other resided having the potential to be affected by the same deficing practice will be identified at what corrective action(s) what correction is potential to be affected by the finding. Facility staff will correct a thorough, detailed inspectic cleanliness of the kitchen are and dry food storage areas is basement of the facility twice each day. Maintenance and Housekeeping Directors will immediately alerted to any identified areas of rodent or pest activity or un-cleanline correction and follow up. The DSM will record all cleaning sanitation tasks for the Dieta Department. Tasks will be designated to be the respon of specific positions in the department. All tasks will be addressed as to the frequent cleaning. A cleaning schedul will be posted for all cleaning tasks and employees will initiasks as completed. What measures will be put into por what systemic changes be made to ensure that the deficient practice does not recur: The facility Pest Confister of the confistions in the deficient practice does not recur: The facility staff will conduct a thorough, detailed inspection for cleanliness of	ient ind vill it the is is induct ion for ea in the ea is be other is for ea and ary sibility excy of ule ea it induct ion for ea in the ear in
FORM CMS-2	567(02-99) Previous Versi	ons Obsolete Event ID:	DEQ911	Facility I	D: 000048 If continuation s	sheet Page 3 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155115	B. WIN			09/23/2	011
NAME OF I	DROVIDED OD GUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		1121 E	LASALLE AVE		
	AL NURSING AND	REHABILITATION CENTER		SOUTH	BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	cart was empty v	where multiple mice			kitchen area and dry food st		
	dropping were n	oted. The second cart had			areas in the basement of the	;	
	three racks of 9	oz drinking glasses			facility twice each day. Maintenance and Housekee	nina	
	stacked on top of	f the cart. The racks were			Directors will be immediately		
	_	e cart and numerous			alerted to any identified area		
		droppings were noted on			rodent or other pest activity		
	the entire top of				un-cleanliness for correction		
	the entire top of	the cart.			follow up. The DSM will reco		
	The aution 1 is 1	en floor was noted to have			cleaning and sanitation task the Dietary Department. Ta		
					will be designated to be the	5//5	
	_	and debris throughout the			responsibility of specific pos	itions	
		the dish washing area			in the department. All tasks		
	floor was wet. A	1" x 2" x 1/2" area of			be addressed as to the frequ		
	debris was noted	under the three			of cleaning. A cleaning sche		
	compartment sin	ık.			will be posted for all cleaning		
	•				tasks and employees will init	tial	
	The following w	et and dirty dishes were			tasks as completed. This in-service will include review	of	
	noted:	or and anti-y dishes were			the facility policy related to p		
	noted.				cleaning of equipment, floors		
	1 2 of 2 holsing	two via vivama ata aliand vivat			storage bins in the kitchen a		
	_	trays were stacked wet.			dry storage areas as well as		
	_	tray with a build up of a			proper procedures for cleani		
	dark tan, sticky s				drying and storage of dishes		
	-	large serving dish with a			Staff will also be re-educated regarding notification and	J	
	dried on substan	ce.			reporting upon observation of	of anv	
	4. 9 of 10 drink	ing glasses noted to be			rodent or other pest activity.	,	
	stacked wet.				in-service will also include re		
	5. 2 of 3 wet co	ffee mugs.			of the facility policy related to	כ	
		g glasses noted with a			proper food storage. The		
		ce inside the glass.			SDC/designee is responsible	e for	
	arioa ori suostari	or morae the plans.			conducting this mandatory in-service. How the correction	VA	
	2 During initial	tour of the dry storess			action(s) will be monitored		
	_	tour of the dry storage			ensure the deficient practic		
		nent on 9/19/11 at 12:20			will not recur, i.e., what qu		
	_	ied by the Dietary			assurance program will be		
	_	ent, the following areas of			into place: To ensure ongoi		
	mice droppings	was observed:			compliance with this correcti	ve	

000048

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	LDING	NSTRUCTION 00	î ´	E SURVEY LETED 2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	 1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN46617	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE
	of the room. 2. On top of the instant potato both apple cider vines. 4. One foil bag a located in a brown container. Multing in the bottom of chewed in the both base aled bottles of the open cardboard cardboard cardboard cases aluminum cansor dry storage area cabinet, dropping shelf next to two plates. During interview on 9/19/11 at 11 the droppings as indicated she has instant apple of the position of the p	closed cardboard box of gar. of non fat dry milk was yn plastic uncovered iple droppings were noted the bin and a hole was ag. rdboard box containing chocolate syrup. dboard box which smaller cardboard boxes, one unsealed box. Within ard box was a plastic, red beans that spilled out		action, a Dietary CQI tool "Daily Cleaning Schedule completed twice daily and than ten times per week, randomly on first and sec shifts, for 3 months and to thereafter. The DSM/des responsible for compliance the cleaning inspections a tools. The ED and/or des will be responsible for mo accurate and timely comp audits and checklists to e tools are completed as as Findings will be submitted CQI Committee for review follow up. By what date to systemic changes will be completed: Compliance 10/23/11	" will be dono less ond hen daily ignee is ewith and CQI elignee nitoring eletion of the example. If to the example and the example is example is example is example.	

	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/23/2	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	1121 E	LASALLE AVE BEND, IN46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	Interview with the 9/19/11 at 4:40 In dietary cleaning further indicated locate the complement of the companied by an 9/20/11 at 10 wet and dirty disconted with a dried inside the contains of the contains o	quart square container and on brown substance ther. uart square container was a way while still wet. acked, cereal bowls. bowls with dried on ving pitchers. plates with a dried on four compartment, loaf we a sticky, yellowish w up tour, the entire floor firty appearance as well as for was again wet. There is build up noted under the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE (COMPL) 09/23/2	ETED
NAME OF	PROVIDER OR SUPPLIEF	\ \			ADDRESS, CITY, STATE, ZIP CODE		
CARDIN	AL NURSING AND	REHABILITATION CENTER			LASALLE AVE BEND, IN46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	Dietary Employer continually mop an attempt to kee further indicated refrigerator so the Dietary Employer A.M., indicated kitchen over the During interview on 9/20/11 at 12 they do not have the kitchen. 4. A third tour at 1:30 P.M., accordinistrator ar Administrator ar Administrator, rounder the refrige bottom shelf of a located next to the buildup was noted on the entry doo washing area. On 9/21/11 at 9: the Administrator, a fourth tour of the and revealed the	evealed mouse droppings arator unit and on the a rolling serving cart the refrigerator. A dust ed on the top of the wall arway into the dish 35 A.M., accompanied by or, Corporate and the Dietary Manager, a se kitchen was conducted					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155115	B. WIN	G		09/23/2	011
NAME OF I	PROVIDER OR SUPPLIER	\			ADDRESS, CITY, STATE, ZIP CODE		
CADDIN	AL NUIDCING AND	DELIABILITATION CENTED			LASALLE AVE		
		REHABILITATION CENTER			I BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG		·		TAG			DATE
		the prep table immediately door as well as behind the					
	1						
	_	ect the upper shelf to the edirt and debris was					
		cky substance as well as a					
	black pebble-like	z substance.					
	A dirt and duct h	ouildup was still noted					
		ne steam unit as well as					
		wave which sits on top of					
	the steam unit.	wave which sits on top of					
	the steam unit.						
	5. On 9/21/11 a	± 0.45 A M					
	accompanied by	•					
		nd the Dietary Manager,					
		rea was noted to be clean					
		lence of rodent droppings.					
	without any evic	ience of rodent droppings.					
	A final tour of th	ne kitchen on 9/21/11 at					
	3:40 P.M., accor						
	-	Corporate Administrator,					
	· ·	ry Manager, the kitchen					
		clean and sanitary without					
		rodent activity or					
	droppings.	rodent activity of					
	droppings.						
	Review of a "(N	ame) Pest Prevention					
	· ·	indicated, "9/21/11					
	•	rviced Kitchen for Light					
		vityOne mouse caught					
		kitchenPlease clean					
	_	ngs. If left in place these					
	droppings could						
		2:41 A.MServiced					
	118K9/21/111	2.41 A.IVISelviced			<u> </u>		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIP A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPL 09/23/2	ETED	
NAME OI	F PROVIDER OR SUPPLIE	R		DDRESS, CITY, STATE, ZIP CODE		
CARDII	NAL NURSING AND	REHABILITATION CENTER		ASALLE AVE BEND, IN46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Serviced Exterior activityPlease and Rubbermaid droppings found Exterior for Heat Serviced Kitcher activity9/14/1 Medium Mouse activityReconf Corrective Activity	mmended Client ons - Dishwash - Please ipment. The debris is pest hen - Clean behind cooler loorRepair Holes, all/Floor Junction in eater room. Large gaps d or 11Serviced Exterior for activity" Titled "Sanitation of 02/02, reviewed 05/06, e dietary staff will itation of the dietary ugh compliance with a				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMPL	
MINDIEMIN	or conduction	155115		LDING		09/23/2	
		100110	B. WIN		DDDECC CITY CTATE ZID CODE	00/20/2	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER			BEND, IN46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	employees will i	nitiai tasks as					
	completed"						
	The immediate jo	eopardy that began on					
	9/19/11 was rem	oved on 9/21/11 when					
	through observat	tions and record reviews,					
	it was determine	d that the facility had					
	implemented the	plan of action to remove					
	the immediacy o	f the problem, but the					
	noncompliance r	emained at the lower					
	scope and severi	ty level of widespread, no					
	actual harm with	potential for more than					
	minimal harm th	at is not immediate					
	jeopardy as the f	acility because ongoing					
	monitoring and f	follow up from the facility					
	and the pest cont	rol company was needed					
	to guarantee the	complete eradication of					
	pest and rodents.						
	3.1-21(i)(2)						
F0469		naintain an effective pest		İ			
SS=L	control program so pests and rodents	o that the facility is free of .					
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		ı	ı			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		OMPLETED	
		155115	B. WIN	G		09/23/2011		
NAME OF E	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
TOTAL OF T	NO VIDER OR SOIT EIE			1121 E	LASALLE AVE			
CARDIN	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN46617			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	record review, the a clean and sanite evidenced by with activity or signs rooms, dining rooms, dining rooms, dining rooms, deficient practices.	ation, interview, and ne facility failed to ensure ary environment as despread signs of rodent of black ants in resident om, a staff office and in dry storage area. This had the potential to 107 residents who reside	F0	469	It is the practice of this provious maintain an effective pest comprogram to ensure the facility free of pests and rodents. We corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice: All specifically ider areas in the kitchen, dry food storage area, medical record storage room, dining room a identified resident rooms have been thoroughly deep cleaned.	entrol y is hat en ntified d I nd	10/23/2011	
	when numerous were identified i multiple areas th The Administrat (DON), Dietary Manager Assista immediate jeopa 9/19/11. The imremoved on 9/21 remained at the level of widespread, no a for more than minemediate jeopa. Findings include				and/or sanitized. How other residents having the potent to be affected by the same deficient practice will be identified and what correct action(s) will be taken: All residents have the potential affected by this finding. A fa "Cleaning Team" will be appointed. This "Cleaning T will conduct a detailed, thore inspection of all resident occurreas. These inspections will include resident rooms, close and drawers. Maintenance and drawers. Maintenance and drawers activity alerted to any identified areas of rodent or pest activity for correction are follow up. What measures we put into place or what systechanges will be made to ensure that the deficient practice does not recur: The	tial ive to be cility eam" upied ill ets and be other id ill be emic		
	11:10 A.M., acco Manager Assista	ompanied by the Dietary nt, multiple mice observed in numerous			facility Pest Control Service continue visit/inspections no than five times per week unt evidence of pest activity is	will less		

NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN46617 (X5)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MU A. BUIL B. WINC	DING	ONSTRUCTION 00	(X3) DATE S COMPL 09/23/20	ETED	
PROVIDER'S PLAN OF CORRECTION				•	1121 E	LASALLE AVE		
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DATE	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
arcas of the kitchen and dish room. During initial tour of the dry storage area in the basement on 9/19/11 at 12:20 P.M., accompanied by the Dietary Manager Assistant, numerous areas of mice droppings was noted on top of the food boxes and within the cardboard boxes. Areas of mice droppings was noted throughout the dry storage room on the floor and in the utility cabinet. Tour of the medical record room in the basement on 9/19/11 at 12:15 P.M., multiple areas of mouse droppings were noted along the perimeter of the room. On 9/19/11 at 1:50 P.M., Room # 113 three mouse droppings were noted based a sticky mouse pad located on the north side of the dresser. Room # 130 on 9/19/11 at 1:50 P.M., multiple, live and dead, black ants were noted on the floor in 1st floor dining room beside the heating/cooling unit. Mouse droppings were noted in Room # 116 on 9/19/11 at 1:55 P.M., underneath Mouse droppings were noted in Room # 116 on 9/19/11 at 1:55 P.M., underneath	TAG	areas of the kitch During initial to in the basement accompanied by Assistant, numer droppings was n boxes and within Areas of mice do throughout the dropping and in the state of the dropping areas of noted along the property of the dress. On 9/19/11 at 1: three mouse dropping a sticky mouse property side of the dress. Room # 130 on ants along with a observed in three cove molding. On 9/19/11 at 1: and dead, black floor in 1st floor heating/cooling.	then and dish room. The area and dish room. The dry storage area on 9/19/11 at 12:20 P.M., the Dietary Manager rous areas of mice oted on top of the food in the cardboard boxes. Toppings was noted try storage room on the attility cabinet. The dry storage area area area area area area area		TAG	eradicated. An all staff in-sec will be conducted on 10/18/1 This in-service will include record the facility policy related to proper cleaning of resident occupied areas including reservices. Staff will also be re-educated regarding notification and reporting procedures upon observation or resident verbalization of any rodent of other pest activity. This in-security will include review of proper removal and proper storage food in resident rooms and occupied areas. The SDC/designee is responsible conducting this in-service. The ED and/or designee will be responsible for monitoring accurate and timely complete audits and checklists to ensure tools are completed as assigned the monitored to ensured deficient practice will not refice, what quality assurance program will be put into plant to ensure ongoing compliant with this corrective action, Composed to the composition of the conduction of the conduc	int. eview of the sident of the contract of t	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUII	DING	00	COMPL	
		155115	B. WIN			09/23/2	UII
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CADDIN	AL AULIDOING AND				LASALLE AVE		
		REHABILITATION CENTER		SOUTH	BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
IAG		· · · · · · · · · · · · · · · · · · ·		1AG		ole.	DAIE
TAG	the heating/coolin All the ants and/onoted on the 1st is being located at it and the basement. Interview with R at 1:50 P.M., she mouse scamper is few times. She fit time she saw a mago. She indicate maintenance's att sticky pad trap be During interview 9/19/11 at 1:50 P saw droppings on mouse. On 9/19/11 at 2:0 indicated he hear in his old room a mice. He further droppings in his of	or rodent activity were floor with the kitchen the south end of the unit area. Resident # 57 on 9/19/11 indicated she saw a sum and out of her room a further indicated the last mouse was a couple weeks seed she brought it to tention and he placed a reside her dresser. What with Resident # 41 on P.M., she indicated she in her floor and a live the side of the place o		TAG	completion of these audit too. The ED and/or designee will responsible for monitoring accurate and timely complet audits and checklists to ensit tools are completed as assigned bata will be submitted to the Committee for review and foup. By what date the syste changes will be completed. Compliance Date = 10/23/11	ols. I be ion of ure all gned. CQI llow imic	DATE
	at 2:05 P.M., he	indicated he saw a mouse					
	this morning and	I further indicated he sees					
	them all the time						
FORM CIVE 2	During interview 9/19/11 at 2:15 P	with Resident # 61 on P.M., she indicated she	DEG. ()	P. W. 7			10.100
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	DEQ911	Facility I	D: 000048 If continuation s	heet Pa	ge 13 of 22

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155115	B. WIN	G		09/23/2	011
NAME OF I	PROVIDER OR SUPPLIER	\ {			ADDRESS, CITY, STATE, ZIP CODE		
CADDIN	AL NUIDCING AND	DELIABILITATION CENTED			LASALLE AVE		
		REHABILITATION CENTER			I BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIC PR F F T Y (EACH CORRECTIVE ACTION SHOULD			(X5)
PREFIX TAG	`	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
IAG		·		IAU			DATE
		ner room two weeks ago					
	and they actually	caught it.					
	Interview with the						
	Interview with the Administrator on 9/19/11 at 2:30 P.M., she indicated no						
		ight to their attention any					
		ent or ant problems.					
	concerns of rode	in of ant proofens.					
	Review of a "(N	ame) Pest Prevention					
	`						
	Service Report," indicated, "9/21/116:35 A.MServiced Kitchen						
	for Light Mouse adult						
	_	med proactive services					
	-	MouseOne mouse					
		void in kitchen. Placed					
	_ ~ ~	up traps in ceiling void in					
		and seal any Holes, or					
	-	e can gain access into					
		rs of facility, including					
		includes pipe chases,					
		et work, etc. These areas					
		spended ceiling. Repair					
	Hole in bottom of						
		f building. Screen in					
		t (sic) inoperable. Please					
		droppings. If left in place					
	-	could pose a health risk					
		com determining if the					
	-	ive or inactive9/21/11					
		viced Common Areas for					
		ivity. Serviced Exterior					
	1 -	activityI sealed holes					
		n and chemical closet.					
		traps to the ceiling at the					
	1 1150 added silap	raps to the centing at the					

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIDENTIFICATION NUM				ONSTRUCTION 00		(X3) DATE COMPL	
THE LEAN	or conduction	155115		A. BUIL				09/23/2	
		100110		B. WING			1 mp. gw 6	00/20/2	V 1 1
NAME OF F	PROVIDER OR SUPPLIER	t				ADDRESS, CITY, STA	ATE, ZIP CODE		
CARDINA	AL NURSING AND	REHABILITATION	CENTER			LASALLE AVE I BEND, IN4661	7		
(X4) ID		TATEMENT OF DEFICIE			ID	<u>,</u> T			(X5)
PREFIX		CY MUST BE PERCEDE			PREFIX	PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	`	LSC IDENTIFYING INF			TAG		ED TO THE APPROPRIAT FICIENCY)	E	DATE
	cubby area. Add	litoinal (sic) STs (snap						
	*	hekitchen (sic), so							
		an laundry room.							
	added 3 new bait stations. There are now								
	8Please Clean all cart equipment and								
		age cabinets. Sor							
		. Repair Holes in							
		all under water pip							
		pair trim wallcov							
		11Serviced Act	_						
	,	Room 2nd Floor for Medium Mouse							
	activity. Serviced Exterior for Heavy								
	Mouse activity. Serviced Kitchen for								
		ivity. Serviced Ro							
	for Light Mouse	-							
	~	mending that mo	re bait						
	stations be placed	•							
	Wall/Floor Junct								
		s large enough for	rodents						
		Holes in stainless							
		behind oven. Re							
		iles in water heate							
		Junction in kitche							
		rge gaps need to b							
		re items off floors							
	much as possible								
	closets9/14/11								
		ormed Regular In	sect						
		tenance Prog (Pro							
		d ESR Extra Serv							
	1	y. Performed Reg							
	Ecosensitive Pest Prevention today. Pest								
	Activity Found: Serviced Dishwash for								
	_	activity. Serviced							
FORM CMS-2	567(02-99) Previous Version	-		DEQ911	Facility 1	ID: 000048	If continuation sh	leet Pa	ge 15 of 22

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			(x2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 09/23/2011		
		100110	B. WIN				09/23/2	011
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STA	ΓE, ZIP CODE		
CVDDIN	AL NITIDGING AND	REHABILITATION CENTER			LASALLE AVE BEND, IN46617			
				<u> </u>	BEND, 1140017			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX		AN OF CORRECTION ACTION SHOULD BE		(X5) COMPLETION
TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)			TAG CROSS-REFERENCED TO THE A			
1710		dium Mouse, Rat activity.	+	1710				DITTE
		n for Light Small Fly						
	activity. Comment: Found small flies in							
		fruit in container, 2 dirty						
	-	ontaining mold, also full						
	urine bottle full	•						
		Client Corrective Actions						
	- Dishwash - Ple							
		debris is pest harborage						
		he effectiveness of						
		ationsPlease continue to						
	clean and dry floors in the dishroomExterior - Please keep							
		osedKitchen - Clean						
	_	ood debris on floorClean						
		ood and debris stuck to						
		Repair Holes, Cracks,						
		eater room. Seal						
		tion in kitchen water						
		arge gaps need to be sealed ructural Repairs Needed						
	_	•						
		nelp solve rodent issuses						
	(sic)Material U	Usage Iwash - Clear Zone						
	1	orExteriorGeneration						
		BlocksKitchen Clear						
	Zone IInsect N							
		ervice Types Performed:						
	I -	ılar Insect Light Trap						
		og today. Performed						
		sitive Pest Prevention						
	today. Pest Activity Found: Serviced							
		dium Mouse activity.						
	Proactive Service	ees Made: Performed						
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event ID:	DEQ911	Facility I	D: 000048	If continuation sh	eet Pa	ge 16 of 22

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 09/23/2011	
			B. WII		DDRESS, CITY, STA	ATE ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	R			LASALLE AVE	ATE, ZII CODE			
CARDIN	AL NURSING AND	REHABILITATION CENTER			BEND, IN4661	7			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEF	ICIENCI)		DATE	
	1 ^	es for pest types: Small							
	· · · · · · · · · · · · · · · · · · ·	use. Recommended Client							
		ons - DishwashPlease							
		n and dry floors in the							
		eriorPlease keep							
	_	osedKitchenRepair							
		Tiles in water heater room.							
		Junction in kitchen water							
		arge gaps need to be sealed							
	or replacedMe								
	RoomsStructur								
	heater to help solve rodent issuses								
	(sic)Material U	•							
	1	wash - Borid, Insect							
		eriorGeneration Mini							
		7/29/11Service Types							
		formed Regular Insect							
		ntenance Prog today.							
		ılar Ecosensitive Pest							
		y. Pest Activity Found -							
		or for Heavy Mouse							
		ive Services Made -							
	_	ctive services for pest							
	types: Small Co	·							
		ended Client Corrective							
		ash - Please continue to							
	clean and dry flo								
		erior - Please keep							
	-	osedKitchen - Repair							
		Tiles in water heater room.							
		Junction in kitchen water							
		arge gaps need to be sealed							
	_	echanical Rooms -							
	Structural Repair	rs Needed water heater to							
FORM CMS-2	567(02-99) Previous Versi	ions Obsolete Event ID:	DEQ91	1 Facility I	D: 000048	If continuation sh	eet Pac	ge 17 of 22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			LDING	NSTRUCTION 00	(X3) DATE COMP 09/23/2	LETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	p. why	1121 E	DDRESS, CITY, STATE, ZIP CODI LASALLE AVE BEND, IN46617	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	SummaryDishon Monitor 8Dry 94ExteriorCor Complete Brand, BaitKitchen - I Monitor6/24/1 Performed - Perf Light Trap Main Performed Regul Prevention today Serviced Exterio activity. Service Mouse activity Found - Serviced Activity. Serviced Activity. Serviced Vendin juvenile activity. Review of a facil "Housekeeping I dated 3/1/11, ind housekeeping serfunctional sanitar	Borid, Insect 1Service Types formed Regular Insect tenance Prog today. ar Ecosensitive Pest 2. Pest Activity Found - ar for Medium Mouse d Kitchen for Light 1.5/25/11Pest Activity l exterior for Light Mouse ed Kitchen for Light Small Fly activity. g for Light Mouse					
	9/19/11 was remethrough observatit was determined	eopardy that began on oved on 9/21/11 when ions and record reviews, d that the facility had					
	implemented the	plan of action to remove					

000048

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 09/23/2011					ETED	
					STREET AT	DDRESS, CITY, STAT	E. ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	-				ASALLE AVE	_,		
		REHABILITATION CE			SOUTH	BEND, IN46617			
(X4) ID		TATEMENT OF DEFICIENC			ID		AN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED E			REFIX	(EACH CORRECTIVE A		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFOR			TAG	DEFICI	IENC1)		DATE
	-	f the problem, but th							
	_	emained at the lowe							
	scope and severit	ty level of widesprea	ad, no						
	actual harm with	potential for more t	han						
	minimal harm th	at is not immediate							
	jeopardy becaus	e ongoing monitorin	ng and						
	follow up from tl	he facility and the pe	est						
	_	needed to be compl							
		complete eradication							
	pest and rodents.	-							
	pest and rodents.								
	3.1-19(f)(4)								
	,,,,								
FORM CMS-2	567(02-99) Previous Version	ons Obsolete	Event ID: DE	EQ911	Facility II	D: 000048	If continuation sl	neet Pa	ge 19 of 22

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/23/2011	
	PROVIDER OR SUPPLIER AL NURSING AND I	REHABILITATION CENTER		1121 E I	DDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0516 SS=C	The facility may re resident-identifiable accordance with a agent agrees not to information except itself is permitted to the facility must sufformation against unauthorized use. Based on observations and the facility must be information against unauthorized use.	lease information that is e to an agent only in contract under which the o use or disclose the to the extent the facility o do so. afeguard clinical record t loss, destruction, or	F0	516	It is the practice of this provio		10/23/2011
	clinical records we protected from unfire, water, and room fire, water, and room fire, water, and room findings included. During the envirous facility on 9/19/1 room housing the (located in the base facility) was four entering the medical cardboard box records were four the room on the bost of resident x-rays unsecured and unfile cabinet. Rode	of closed clinical ile drawers of closed were secured and nauthorized access, ident damage. commental tour of the 1 at 12:15 P.M., the e closed medical records issement level of the ind unlocked. Upon ical record storage room, ites of unsecured clinical ind scattered throughout basement floor. Four sets			is safeguarded against loss, destruction or unauthorized access, fire, water and roden damage. What corrective action(s) will be accomplish for those residents found to have been affected by the deficient practice: The identiclosed medical record storag room locks have been replace and new keys have been distributed only to appropriate personnel. The identified x-r boxes and files drawers of clinical records have been properly stored and secured facility policy. All evidence o rodent activity has been eliminated. How other reside having the potential to be affected by the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action(s) where the same deficient practice will be identified at what corrective action actio	tified tified e e e e ays, osed per f e e tifie e tified e e ays, osed b e tified tified e tified	

000048

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155115	B. WIN			09/23/201	11
			Б. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER			BEND, IN46617		
					DEND, IN-10017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	1	ıkler heads were also			storage room locks have been		
	observed directly above the cardboard				replaced and new keys have been distributed only to	;	
	boxes that contained the clinical records.				appropriate personnel. The		
	During an interview with the				identified x-rays, boxes and	files	
					drawers of closed clinical red		
	<u> </u>				have been properly stored a		
		Administrator on 9/19/11 at 12:30 P.M.,			secured per facility policy. A	All	
	she indicated the records, which were observed in the cardboard boxes, should have been secured in metal filing cabinets. During interview with the Director of				evidence of rodent activity ha		
					been eliminated. What meas		
					will be put into place or wh		
					systemic changes will be n		
					to ensure that the deficient practice does not recur: Th		
	Nursing on 9/23/11 at 10:20 A.M., she indicated all the records observed, in the				SDC/designee will conduct a		
					staff in-service on 10/18/11.		
		d room, housed only			in-service will include review	of	
		ecords of residents no			the facility policy regarding c	linical	
					record storage and authorize		
	longer residing i	if the facility.			access to clinical records as		
					as cleaning and maintenanc	e of	
		or indicated in an			all storage areas. How the corrective action(s) will be		
	interview on 9/2	3/11 at 11:05 A.M., "The			monitored to ensure the		
	lower level floor	of the facility is			deficient practice will not r	ecur.	
	accessible to all	employees."			i.e., what quality assurance		
					program will be put into pla		
	A facility policy	titled "Retention and			Ongoing compliance with thi	s	
		ed, indicated, "All clinical			corrective action will be mon		
					through completion of the Co	ગ્રા	
		nd computer based, shall			tool titled, "Care Rep Daily	orago	
		anner that safeguards			Rounds Medical Records/Sto Area Checklist" twice daily a	~	
		nformation from loss,			less than ten times per week		
		unauthorized use.			randomly on first and second		
	Records shall be	stored in a manner that			shifts for 3 months and daily		
	maintains the co	nfidentiality of			thereafter for six months. The	ne	
		tained in the records"			Maintenance Director, Medio	cal	
					Records/designee will be	_	
	3.1-50(d)				responsible for completion o		
	3.1-30(u)				these audit tools. The ED at		
					designee will be responsible	IUI	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 09/23/20	ETED
	ROVIDER OR SUPPLIER		<u> </u>	1121 E	DDRESS, CITY, STATE, ZIP CODE LASALLE AVE		
		REHABILITATION CENTER		<u> </u>	BEND, IN46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	monitoring accurate and time completion of audits and checklists to ensure all tools completed as assigned. Find will be submitted to the CQI Committee for review and fol up. By what date the system changes will be completed: Compliance Date: 10/23/11	are lings low nic	DATE